18

MANAGEMENT PROBLEMS IN FEDERAL HEALTH PROGRAMS

Y 4. B 85/3: 103-3

Management Problems in Federal Heal...

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

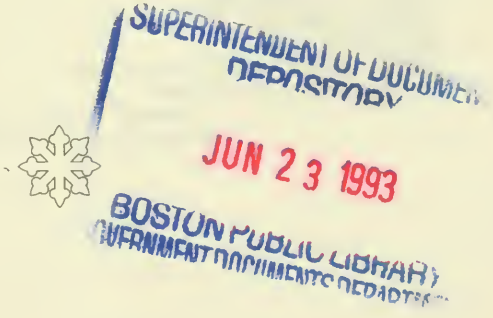
ONE HUNDRED THIRD CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, FEBRUARY 17, 1993

Serial No. 103-3

Printed for the use of the Committee on the Budget



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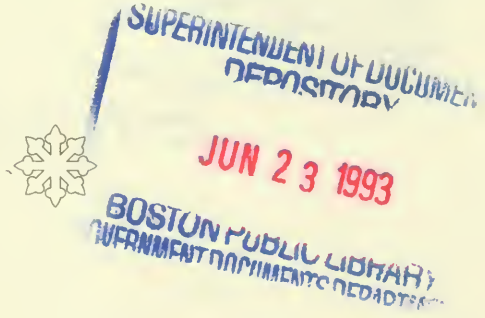

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MANAGEMENT PROBLEMS IN FEDERAL HEALTH PROGRAMS

WEDNESDAY, FEBRUARY 17, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, DC.

The committee met, pursuant to notice, at 2:12 p.m., Room 210, Cannon House Office Building, Hon. Martin Olav Sabo, Chairman, presiding.

Members present: Representatives Sabo, Stenholm, Gordon, Mink, Orton, Pomeroy, Kasich, McMillan, Snowe, Herger, Allard, Miller, and Hoke.

Mr. ORTON. [Presiding.] In the interest of time, we are going to begin this meeting. The Chairman is on his way here. But without objection, any opening statements by members will be included in the record including the opening statements of the Chairman.

[The prepared statements of Hon. Martin Olav Sabo and Hon. Jerry F. Costello follow:]

PREPARED STATEMENT OF HON. MARTIN OLAV SABO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

This afternoon the committee will continue its review of Federal health programs, focusing on management problems in the medicare program. Our witness is Janet L. Shikles, Director of Health Financing and Policy Issues at the General Accounting Office.

In many respects, medicare is one of the real success stories of our Government. The program assures universal health insurance coverage for all of our citizens who are 65 years of age and over and also provides coverage for the disabled.

While we praise the successes of medicare, however, we should not ignore the problems in the program which need to be addressed. Last December, the General Accounting Office identified medicare and 16 other Federal programs as being at "high risk" for fraud, abuse and mismanagement. According to the GAO, the Health Care Financing Administration (HCFA) and the medicare contractors lack the management systems to guard against fraud and abuse.

It is always important that we manage taxpayer dollars as carefully as possible. However, in the case of medicare it is especially critical that we do so at this time. The success of our efforts to bring the deficit under control will be largely affected by how well we control the rate of growth of Federal health programs. And any efforts to close the current gap in coverage for nonelderly Americans will require the use of savings from health care reform.

Furthermore, wasting medicare monies increases the health care burden on the elderly and disabled. While medicare provides universal access to health coverage for the elderly, the program pays less than one-half of their medical bills. The proportion of health care costs which are shifted to the elderly and others will increase over time unless medicare growth rates are reduced. Our witness, Ms. Janet Shikles, is with us to discuss the GAO findings regarding problems in managing medicare. She will share with us the GAO recommendations on how to improve the management of the medicare program. The House Budget Committee asked the General Accounting Office to review how the medicare contractors manage the program and

to report to us on the specific activities that appear to result in the most efficient management policies and procedures.

Ms. Shikles, we thank you for testifying before this committee today.

PREPARED STATEMENT OF HON. JERRY F. COSTELLO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. Chairman, I am pleased to be here today to hear testimony from the Director of Health Financing and Policy Issues at the General Accounting Office. I would like to welcome Janet Shikles and I look forward to her testimony today regarding the management problems in federal health programs.

This morning we heard testimony from Dr. Reischauer of CBO who confirmed by belief that health care reform must be a top priority for this Congress and this nation. Health care costs are spiralling and we must bring health care costs under control if we are going to bring federal spending under control and reduce the budget deficit.

I am very concerned about the cost of federal health programs, such as Medicare. Medicare, as the largest of the federal health programs, cost almost $120 billion in 1992. I am interested in examining changes in the management of the Medicare program to find cost savings.

In my district in Southwestern Illinois I recently held an Aging Committee field hearing to address the issue of health care fraud. I am hopeful that through today's hearing we can explore this issue further in order to find effective solutions to the growing number of fraudulent medical claims that are plaguing our system of health care financing.

Mr. Chairman, thank you for calling this hearing and for your leadership of this committee.

Mr. KASICH. I wanted to have an opportunity just to say one thing. I think waste, fraud and abuse is a big category in Washington. The problem is as I say to, let me try to get it right, is it Ms. Shikles?

Ms. SHIKLES. Shikles.

Mr. KASICH. With a name like Kasich, I never get it pronounced right. Ms. Shikles, we always talk and shake our heads about waste, fraud and abuse and we do not seem to ever do anything about it. So I would like to not only know a little bit about the waste, fraud and abuse that is out there, but also the kind of things that you think we can do in a substantive way to make an impact on it.

Thank you.

Mr. ORTON. Thank you, Mr. Kasich.

Which one of you would like to start off?

Ms. Shikles?

STATEMENT OF JANET L. SHIKLES, DIRECTOR, HEALTH FINANCING AND POLICY ISSUES, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY EDWIN P. STROPKO AND THOMAS G. DOWDAL

Ms. SHIKLES. Thank you, I will.

I would like to introduce my colleagues Ed Stropko on my right and Tom Dowdal on my left, also with the General Accounting Office.

I will begin. Mr. Chairman and members of the committee. I am pleased to be here today to discuss problems in the management of the medicare program which are resulting in unnecessary expenditures. Today I want to focus my testimony on the contractors payment safeguard activities which are intended to protect the program from fraud and abuse.

In recent years, these activities have returned over $12 for every $1 invested in them. These contractors which are basically private health insurers, have three major responsibilities.

They are responsible for paying medicare claims. They are also responsible for providing and answering questions from providers and beneficiaries and they are also responsible for managing a set of activities that are referred to as payment safeguard activities.

These activities involve a couple things. They are responsible for setting medical policies.

In other words, if somebody is going to send in a bill for a wheelchair, then they will decide before they pay that bill, they want a physician to say the wheelchair is necessary. They are also responsible for setting up computer screens or edits so that when the bill comes in it is not paid unless specific medical criteria are met.

They also set up policies or computer edits after the bill is paid to see if everything is being followed. And one example illustrates why this activity is so important and represents such high expenditures from medicare.

We were recently at one of these contractors and looking at their data and working with them, found that they have seen almost a 15-fold increase for a procedure called echocardiograms which are procedures doctors use to look at the heart. They saw a jump in 2 years time from $580,000 to $10 million. Now they had no medical policies in place. They had no computer screens, so whatever comes in to the medicare program they just pay.

The reason this is important is it is probably not just a problem or a question for this contractor, but it is a national issue. Because when we looked at how much we are spending for echocardiograms across the country, we found that we are spending $366 million in 1992. This is a sudden increase for these services.

Now the importance of contractors being vigilant over what is being spent in the medicare program is increasing because of what is happening in the health care program. Increasingly you are finding that health care is moving outside of a hospital which is controlled and regulated and it is moving into free-standing, unregulated facilities that are also often unlicensed by States.

In addition, you are increasingly having physicians invest in these free-standing facilities where they might refer their patients. And all previous research has shown that when physicians are also owners of where they refer patients, you end up with twice as many tests being done. This means more services that medicare has to pay for are often unnecessary services.

So because of the environment that is changing in health care, you need contractors to be very vigilant and it is increasingly a complex environment.

Well, contractors are also seeing a surge in claims. This year they will pay about 100 million claims for hospital-base services but they are expected to pay 630 million claims for these nonhospital base services like echocardiograms. This represents a 55 percent increase over the amount of claims they were paying just a couple years ago.

So they are seeing a more complex, more tricky health environment, often unregulated, and a surge in claims at the same time

that the funding for the activities to watch over these expenditures has declined.

So when we visited about 11 contractors in the last several months and looked at the kinds of controls and edits they are running, because their funding has not kept pace with what is going on in health care field and the kinds of claims coming in. They are running fewer edits.

They are finding that they are not developing medical policies on these new procedures that are becoming very expensive like echocardiograms. They are finding that they are having to shut off the kinds of screens that they have just been running for a long time because they do not have enough staff to look at them.

So there is no point running the edit, if you cannot have anybody look at what you might find.

And in fact, HCFA, which has required contractors to screen about 12 percent of all claims last year, this year because of the decline in funding, asked them to review only 9 percent of all claims. That means that about 91 percent of all claims that medicare pays this year will not be looked at.

Now in addition to our concern about adequate funding for these payment safeguard activities, we are also concerned because we believe that the medicare program is suffering from serious management weaknesses.

In our ongoing work that we are doing for this committee and others, we find that HCFA does not have the kinds of management data that it needs to compare contractor performance. It does not know where it has problems. Problems often become widespread before HCFA is aware that it has a national problem.

Contractors that we have recently visited have identified a surge in payment for different activities and yet they do not have the controls in place. They have not developed policies to know whether they should pay for these services or not.

And I will give you two examples. One is that contractors are very concerned about a surge in claims for laboratory services and whether they are paying for services that are appropriate.

And there was a recent settlement against a national laboratory where they got $110 million settlement against a company that will be paid to medicare and other Federal payers. And this is because they were billing inappropriately for cholesterol and ferritin tests.

The problem is that none of the claimed edit were in place to catch this and yet these should have been easy things to pick up. You should have been able to find out that all of a sudden every medicare beneficiary who went to a doctor started getting billed for these additional tests.

Another concern that contractors are raising with us is that they are seeing a surge in claims for ambulance services, almost a 30 percent increase over the past 5 years.

Now one contractor believes this is really being used for routine transportation and yet there are no controls in place; no one is really looking at this; and yet this is their fourth highest expenditure in their area. It is also expensive nationally. In 1992, we spent over a billion dollars for ambulance services under the medicare program.

In addition, we are also concerned that limited HCFA direction to medicare contractors is another factor that has led to break down and how the contractors are managed.

In the past, we have reported on problems in medicare's failure to adequately investigate beneficiaries who have called in and identified problems in fraud, waste, and abuse. We have identified problems when contractors failed to recover money from hospitals when they had overpaid or were duplicate payments.

Sometimes the hospitals have tried to return the money and they did not take it back. Sometimes hospitals just decided to write the money off.

We have also identified problems where medicare is paid an estimated $2 billion that should have been paid by other insurers. They were very slow to recover this money and still have not recovered most of it. And we have also reported on loose controls over who can bill the program that has led to fraud and abuse.

In conclusion, we recognize that budget constraints are more severe than ever and administrative budgets of all Federal programs are at risk. However, in our view, given the condition of the medicare safeguard program, we are concerned that reductions in medicare's administrative budget could lead in the future to additional and unnecessary entitlement spending.

In addition, we believe that HCFA needs to develop a national strategy to manage the safeguard activity. What we would like to see a new administrator do is to put a new strategy in place; give it new importance; and assess the whole appropriateness and effectiveness of the kinds of controls you need; those controls that should be operated at the contractor level and manage it so that they actually get done.

We believe that a strategy like this would help assure that HCFA is monitoring its program which is very decentralized, as you know, and would be more effective in fighting fraud and abuse.

Mr. Chairman, this concludes my statement and I would be happy to take any questions.

[The prepared statement of Janet L. Shikles follows:]

PREPARED STATEMENT OF JANET L. SHIKLES, DIRECTOR, HEALTH FINANCING AND POLICY ISSUES, HUMAN RESOURCES DIVISION, UNITED STATES GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Committee, the need for the government to manage Federal health costs effectively is underscored by the fact that Federal health programs consumed over 15 percent of the Federal budget in 1992. Medicare is the largest of these programs. In 1992 it cost almost $120 billion, enrolled over 35 million beneficiaries, and processed about 700 million claims. If current trends continue, Medicare expenditures are expected to nearly double by 1998 to $239 billion.

Concerned about curbing unnecessary Medicare expenditures, the Congress has asked us to examine numerous Medicare management problems. Two major problems emerge from our work in this area. First, the Health Care Financing Administration (HCFA), the agency that oversees Medicare, does not have an effective, national strategy to protect the program from making erroneous or wasteful payments. Second, budget constraints have led to the underfunding of the types of payment controls that prevent or detect losses due to waste, fraud, and abuse.

Evidence that HCFA has not actively managed these controls and that funding is insufficient is seen in a range of problems that we have reported on over the past several years. We have found, for example, that: Medicare had failed to adequately

investigate complaints of fraud and abuse telephoned in by Medicare beneficiaries.[1] Little was done initially to reclaim over $250 million in overpayments owed by hospitals.[2] An estimated $2 billion in claims had been paid by Medicare that may have been the responsibility of other health insurers.[3] Loose controls over who can bill Medicare have allowed profiteers to exploit the program through fraud and abuse.[4]

In other hearings and reports, we have made recommendations aimed at better management of various activities and at adequate funding of safeguard efforts. While HCFA has taken actions to correct many of the specific problems we and others have identified, it has not developed a systematic approach to managing the safeguard program. Developing such a strategy is not an easy task but we believe it is essential to better control unnecessary payments.

MEDICARE PROGRAM MANAGED LARGELY THROUGH PRIVATE INSURERS

In 1965, when the Medicare program was enacted, the law provided for insurance companies—like Blue Cross/Blue Shield, Travelers, and Aetna, to name a few—to process and pay claims. Under the law, the insurers, called Medicare contractors, used Federal funds to pay health care providers and beneficiaries and were reimbursed for their administrative expenses incurred in performing the work. This arrangement was pragmatic in that the insurance companies had both claims-processing experience and an understanding of the medical practices of their communities.

Over the years, HCFA has consolidated some of Medicare's operations and the number of contractors has fallen from about 130 to about 80 today. Their duties encompass three major functions: claims processing, provider and beneficiary services, and payment control activities, called payment safeguards. In 1993 the contractor budget is approximately $1.6 billion, with about 25 percent devoted to payment safeguard activities.

PAYMENT CONTROLS HAVE SAVED $12 FOR EVERY $1 SPENT

I want to focus today's testimony on the contractors' payment safeguard activities which in recent years have returned over $12 for every $1 dollar invested. These activities consist of various controls that occur throughout the process of paying and reviewing claims. Some controls, called prepayment screens, are computerized edits that are in place when a claim is entered into the contractor's automated claims processing system. The screens detect certain irregularities that result in automatic denials or suspensions of claims for further review before payment. For example, contractors limit the number of chiropractic visits per month for which they will pay. Similarly, contractors require a physician's certificate stipulating the need for a wheelchair before they will make this payment. Prepayment screens, therefore, are programmed to suspend claims that exceed a specified limit on chiropractic visits and for claims for wheelchairs that have not been adequately documented for medical necessity.

Other controls occur after the payments are made. Contractors use a technique called profiling to identify physicians and other providers who bill for many more services, such as diagnostic scans, than their peers. Profiling can lead to reviews or audits used to examine providers' billing abuses, such as upcoding (that is, upgrading a procedure to one that is reimbursed at a higher rate) and unbundling (splitting one procedure into several to increase the reimbursement total).

Prepayment screens and postpayment reviews are shaped in large measure by the contractors' medical policies. These policies embody the criteria used to establish the conditions under which Medicare will pay claims for certain medical services or procedures. Using medical policies, contractors develop the computer screens that suspend or deny claims for exceeding specified limits. Contractors determine which services will be covered by medical policies generally at their own discretion. In the absence of a medical policy for a given service, claims for those services, if otherwise complete, are paid and are not likely to be reviewed for appropriateness.

One example illustrates the importance of establishing medical policies to help assure that Medicare does not pay for unnecessary or inappropriate services. A contractor we recently visited identified over a 15-fold increase in expenditures, from

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[1] *Medicare: Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse* (GAO/HRD-92-1, Oct. 2, 1991). Testimony on same topic (GAO/T-HRD-92-2, Oct. 2, 1991).

[2] *Medicare: Millions of Dollars in Mistaken Payments Not Recovered* (GAO/HRD-92-26, Oct. 21, 1991).

[3] *Medicare: Over $1 Billion Should Be Recovered From Primary Health Insurers* (GAO/HRD-92-52, Feb. 21, 1991).

[4] *Medicare: One Scheme Illustrates Vulnerabilities to Fraud* (GAO/HRD-92-76, Aug. 26, 1992).

about $580,000 to $10 million between 1989 and 1991, for echocardiograms (a procedure that allows doctors to view an image of the heart). The contractor had no medical policy regarding this test and thus no basis for questioning the appropriateness of the claims.

Echocardiograms are illustrative of the types of services that are candidates for close scrutiny at a national level. For one kind of echocardiogram, for example, Medicare spent nationwide $366 million in 1992.* The rapid growth in medical expenditures for services like echocardiograms emphasizes the importance of contractors' vigilance over the appropriateness of payments for these services and the need for ongoing development of medical policies and new screens.

CONTROLS OVER MEDICARE PAYMENTS DETERIORATE DUE TO BUDGET CONSTRAINTS

The importance of contractor vigilance over Medicare claims is in fact growing because the environment in which contractors operate is becoming increasingly complex. In recent years doctors and other providers have been moving more services out of relatively regulated environments such as hospitals, to largely unregulated and sometimes unlicensed freestanding facilities. Physicians are also increasingly becoming owners of the facilities to which they refer patients, which can increase incentives to overuse services and add to Medicare's costs.

These trends complicate what has always been a difficult task of identifying and preventing or recovering losses from those who inappropriately bill the program. Accompanying these trends has been an explosion in nonhospital claims that Medicare has to pay. Compared to 107 million claims for inpatient and outpatient hospital services, nonhospital claims are expected to soar to 630 million claims in 1993. This represents a 55-percent increase in such claims since 1989.

Despite these growing complications and rising claims volume, over the past 5 years, budgetary constraints have led to a reduction in Medicare's program safeguard activities. Since 1989, contractors' per claim funding for payment safeguards has declined by over 24 percent. The largest portion of contractor safeguard funding pays for staff who review claims and investigate suspect providers. When claims volume increases but the number of safeguard staff remains constant or declines, contractor staff review a lower percentage of claims.

Not surprisingly, as a result of per claim funding reductions contractors are currently reviewing fewer claims and fewer providers. For example, in 1992 HCFA set targets for contractors to suspend and review 12 percent of all claims. The agency has now reduced this target to 9 percent in 1993. HCFA also reduced the number of provider reviews required by a third.

At some contractors we recently visited, funding constraints have led to less effort spent developing medical policies and screens, simply because the staff is not available to develop screens or to investigate the claims that have been suspended for review. One contractor told us that the workload created by existing medical policies and screens overwhelmed the staff; adding new medical policies and screens was not a priority. In fact, several contractors eliminated some screens because the volume of suspended claims exceeded the capacity of the staff to process them promptly.

WEAK HCFA MANAGEMENT EXACERBATES MEDICARE CONTROL PROBLEMS

As well as inadequate funding for payment safeguard activities, the Medicare program is also suffering from management weaknesses. HCFA has poor management information on such fundamental contractor controls as medical policies and screens. Thus, HCFA is not in a position to actively manage Medicare's overall program safeguards. In addition, the agency has not always provided adequate guidance to contractors on such matters as recovering overpayments and investigating complaints alleging fraud and abuse.

Management Information System Weaknesses

In our ongoing work, for example, we find that HCFA cannot rely on management information to compare contractor performance in payment safeguard areas. Moreover, HCFA has not compiled information on contractors' controls and cannot systematically identify where important controls may be needed. Consequently, it is not uncommon for HCFA to be unaware of problems until they become widespread.

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* See Appendix I for a listing of the top 30 nonhospital procedures that Medicare spent the most on in 1992.

This was the situation when the durable medical equipment (DME) scandals were documented by this committee last year. Several contractors had medical policies and screens that allowed for nearly unconditional reimbursement and favorable payment rates for supplies and equipment. Unscrupulous suppliers took advantage by billing the contractors with liberal medical policies and high payment rates.

Weak controls can have dramatic effects on Medicare expenditures. For example, inadequate controls on seat-lift chairs at one contractor we reviewed allowed a five-fold increase in expenditures to occur over a 1-year period. During this time suppliers were mass-marketing the chairs in the contractor's area. Strengthening its controls and claims reviews resulted in the contractor reducing these expenditures from about $3.5 million in 1986 to about $50,000 by 1990.

Many examples of serious payment problems are documented in the DME area, and steps are now being taken to close some of the loopholes in policies and procedures that allowed these problems to flourish. HCFA is also in the process of reducing the number of contractors who will process DME claims to four. Our work is showing, however, that serious payment problems are not unique to DME suppliers.

Contractors we recently visited in the course of several ongoing reviews pointed to instances where Medicare payments were growing dramatically and needed to be investigated. In some cases the problems stem from the lack of effective medical policies or screens; in others, resources simply were not available or adequate to address the problems. The following examples illustrate the problems contractors face in controlling the outflow of Medicare payments:

Several contractors reported problems detecting and avoiding unnecessary clinical laboratory tests. A sense of the scope of this problem can be seen in a recently settled fraud case against a national laboratory. The laboratory pled guilty to submitting false claims to the government and agreed to repay more than $110 million in settlements and fines. The laboratory led doctors to believe it could perform additional blood tests, though medically unnecessary, at little or no cost when doctors ordered a routine battery of chemistry tests. In fact, the laboratory billed Medicare and other public insurers for the tests. Contractors policies and screens were not effective in stopping such payments.

One contractor experienced an annual growth rate in basic ambulance service expenditures of about 30 percent over the past 5 years. The contractor believes much of the increase could result from the use of ambulances for routine transportation, a noncovered service. Basic ambulance services were the fourth largest category of the contractor's expenditures, yet no computerized screens existed to flag questionable claims. This is potentially a problem for other contractors. Nationwide Medicare has spent over $1 billion for ambulance services in 1992.

Consequences of Weak HCFA Guidance

Limited HCFA direction to Medicare contractors is another factor that has contributed to a breakdown in program protections. Our recent work has addressed the investigation and referral of beneficiary complaints and contractors' failure to recover millions of dollars in Medicare overpayments. HCFA has begun implementing corrective actions for these problems, and early results show that substantial savings can be achieved when contractors take concerted actions.

For example, in one recent study we found that HCFA provided virtually no program guidance to Medicare contractors regarding the investigation of beneficiary complaints—a primary source of fraud, waste, and abuse leads. Inadequate investigation of these complaints can result in missed opportunities to recover overpayments and to send a message that fraudulent or abusive behavior will not be tolerated. In one instance, a provider was initially pursued for billing irregularities because of beneficiary complaints. Upon further investigation, 100 apparently similar complaints surfaced, encompassing about 300 fraudulent claims. The provider involved agreed to refund over $2.5 million to the Federal Government.

In another study, we reported that HCFA was not giving adequate program guidance to Medicare contractors regarding the recovery of hospital overpayments. At last count, the refundable amounts exceeded $250 million, $180 million of which has been recovered. Many of the hospitals had amounts outstanding for several years though contractors were doing little, and in many cases nothing, to recover amounts owed to Medicare.

We found similar problems with contractor efforts to recover claims that Medicare mistakenly paid that may have been the responsibility of other insurers to pay. Specifically, contractors were doing little to recover what we estimated to be about $2 billion in such claims. Some progress has been made in recovering these amounts

over the past year. However, the problem remains particularly severe at one contractor which currently is behind in collecting $425 million in mistaken payments.

IMPROVED PROGRAM SAFEGUARDS PROMISE HIGH RETURNS

Work we are doing for this committee suggests that better management coupled with more funding for program safeguard activities can lower the program's exposure to overpayments. We are examining the results of a recently completed HCFA demonstration project to assess the effects of funding and greater management emphasis on contractors' payment safeguard programs. We are finding that the demonstration contractors that improved their medical policies and added screens enhanced their ability to avoid making inappropriate payments. During the study period one contractor developed 56 new medical policies. From 1988 to 1991 the contractor more than doubled its savings from $10.8 million to $23.4 million. The contractor achieved these savings with an increase in payment safeguard costs of about 7 percent annually. This contractor's performance confirms earlier studies that have established a positive relationship between program savings and more money and management attention for program administration.

CONCLUSIONS

Currently, budget constraints are more severe than ever and the administrative budgets of all Federal programs are in jeopardy of being cut. However, in our view, given the condition of the Medicare safeguard program, reductions in Medicare's administrative budgets should not be made without careful consideration of the likely effect on program safeguards. Over the past 5 years Medicare's program safeguards have declined appreciably. As a result, opportunities to curb unnecessary Medicare expenditures are being lost.

We believe the Congress should continue to pursue efforts to modify budget procedures so that safeguard funding could be increased without having to cut spending elsewhere. Under current budget procedures, administrative funding can be increased only if funding for other programs, such as immunizations or job training, is reduced. For example, although $10 spent on program safeguard activities could save $120 in Medicare entitlement spending, no credit would be given (or scored) for the savings, while the $10 would be counted as an increase in Federal discretionary spending levels. The fact that payment safeguard expenditures are part of the domestic discretionary budget means that they must compete against programmatic funding.

Under the Budget Enforcement Act of 1990, the Congress provided for increasing appropriations for Internal Revenue Service (IRS) compliance activities without necessitating spending cuts elsewhere.[5] As we reported in 1991, we believe using IRS' method of funding compliance activities as a potential model would enable the Congress to appropriate the funding needed for Medicare contractors' staffing and performance of payment safeguard activities.

In addition, we believe that HCFA needs to develop a national strategy to manage the Medicare safeguard program. This would entail: assessing the appropriateness and effectiveness of the whole range of individual contractors' controls, including medical policies, screens, and other controls for curbing unnecessary expenditures, and developing methods to assure that controls that have been shown to be effective are implemented across the country.

Such a strategy could help assure that HCFA monitors its decentralized contractor operations more effectively and that Medicare has the controls in place to aggressively fight fraud and abuse.

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[5] *Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs* (GAO/HRD-91-67, May 15, 1991).

APPENDIX I

1992 Part B Expenditures: Top 30 Procedures

Ranking	Procedure Code Description	Allowed Charges	Allowed Services	Charge Per Service
1	Office/Outpatient Visit: Established Patient (RVU=1)	$1,913,779,797	67,137,128	$28.51
2	Extracapsular Cataract Removal with Insertion	$1,809,610,575	1,989,494	$909 58
3	Subsequent Hospital Care (RVU=1.45)	$1,070,038,822	27,602,583	$38 77
4	Office/Outpatient Visit: Established Patient (RVU=1.52)	$989,488,217	22,931,380	$43 15
5	Subsequent Hospital Care (RVU=1.01)	$863,824,956	29,346,970	$29 43
6	Office/Outpatient Visit: Established Patient (RVU=.72)	$610,189,860	29,363,821	$20 78
7	Subsequent Hospital Care (RVU=1.95)	$429,481,892	8,859,841	$48.48
8	Ambulance Service, Basic Life Support	$374,031,655	3,063,214	$122.10
9	Echocardiography, Real Time w/ Image Documentation	$366,289,396	2,837,143	$129 11
10	Office/Outpatient Visit· Established Patient (RVU=2.34)	$333,887,933	5,159,409	$64.71
11	Level IV– –Surgical Pathology: Gross/Microscopic Exam	$338,787,993	6,053,981	$55.96
12	Initial Hospital Care (RVU=3.83)	$321,809,238	3,271,457	$98 37
13	Discission of Secondary Membraneous Cataract	$317,650,225	735,493	$431 89
14	Initial Inpatient Consultation (RVU=3.69)	$300,439,226	2,758,813	$108 90
15	Radiologic Examination, Chest, Two Views	$297,790,197	16,313,973	$18 25
16	Ambulance Service, Advanced Life Support	$283,230,220	1,262,042	$224 42
17	Individual Psychotherapy by a Physician 45–50 Minutes	$257,730,799	3,986,814	$64.65
18	Ophthalmological Services: Medical Examination	$245,455,827	5,308,257	$46.24
19	Arthroplasty, Knee, Condyle and Plateau	$235,118,695	167,202	$1,406.20
20	Initial Hospital Care (RVU=3 03)	$230,041,749	2,762,751	$83 27
21	Hospital Discharge Day Management	$216,088,664	5,009,078	$43.14
22	Oxygen Concentrator	$215,915,858	848,676	$254 41
23	Combined Left Heart Catheterization	$214,975,855	335,915	$639 97
24	Automated Multichannel Test	$211,357,501	16,639,160	$12.70
25	Office Consultation (RVU=3.66)	$200,094,629	1,882,615	$106 29
26	Leuprolide Acetate, For Depot Suspension, 7.5 Mg	$191,786,591	2,371,613	$80 87
27	Electrocardiogram, Routine ECG	$188,196,772	9,043,975	$20 81
28	Manipulation of Spine by Chiropractor	$185,757,880	10,157,771	$18 29
29	Weekly Radiation Therapy Management	$180,655,364	1,971,635	$91 63
30	Enteral Formulae	$178,870,286	286,966,123	$0 62

Mr. ORTON. Do either of your colleagues have statements or comments that they would like to make?

Ms. SHIKLES. No.

Mr. ORTON. Do you have specific recommendations about what we should be doing in closer monitoring?

For instance, would you recommend increasing the number of auditors or investigators?

In fact, I believe I have seen and I do not know if this is accurate—maybe you can tell me—that there is some disagreement between GAO and CBO about the effectiveness of increasing the regulators, the enforcement, the auditors, the investigators and so on, and whether or not that has an impact?

And if it does have an impact, whether it is cost effective to do that or do you have other recommendations for increasing the effectiveness?

Ms. SHIKLES. First, I do not think there is a disagreement between CBO and GAO. The payment safeguard activities or estimates are really the Health Care Financing Administration's estimates of how much money you can save when you have these types of procedures in place. And the Inspector General has looked at them and thinks that these are reasonable estimates.

We are also doing some work for this committee that is looking very carefully at several contractors and how much money is recovered, and preliminary results suggest that these are very reasonable estimates.

Back to your original question, we have a set of recommendations. I am not certain at this point, just focusing on the Health Care Financing Administration, that you would want to look to new staff just yet. What we found is that HCFA in the past year has started to do some things that do make sense to get a handle on this payment safeguard activity.

But you really need and we would like to see a new administrator get in there and figure out a new strategy. I think if you ran a business and then you looked at how medicare runs the contractor operations, you would be pretty surprised. They do not even have very basic trend data.

If you went out to a contractor and you said, well where is all the money going? They could not tell you. You would like to monitor that spending and know if you have a surge in ambulance spending.

What is going on here? Is this legitimate? Are there all of a sudden an influx of people who really need ambulance services or is there some kind of scam going on or is somebody billing us unnecessarily? And that requires not very sophisticated computer tools and not sophisticated data systems.

My point is that HCFA has not required sort of minimum data to be collected by the contractors across the country to just monitor what is being spent on the medicare program. And I think that is one thing you would want done. Then you would want the new HCFA administrator to elevate this whole payment safeguard activity.

HCFA has spent a lot of time on claims' payment, a lot of time on how to pay for physician services, and the whole management of

where we spend our money is kind of buried in the Agency. It has not been a priority. It kind of gets the last bit of attention.

We would like to see it elevated; maybe given somebody very senior in charge; and then come up with a strategy. What are the data requirements for the contractors; what screens should be in place; and all the contractors should run them. Look at managed care companies for some of the more sophisticated tools that some of the HMO's are using that medicare could be using.

So I think before you went into staffing, you would want to figure out a plan.

Chairman SABO. [Presiding.] Follow up your question, Bill.

Mr. ORTON. Thank you.

I will now come down to my regular seat and follow up. So you are not just suggesting an increase in the audit activity of physicians which may be duplicative and so on; you are actually suggesting specific management reforms which would be aimed at gathering the information necessary in order to make the types of decisions.

I know that the medicare program has also gradually been moving toward electronic processing of Part A and B claims. Has GAO done any analysis to determine an approximation of what could be saved, if all of the claims were filed electronically or as many as feasible?

Ms. SHIKLES. I do not think we have done a specific analysis on what could be saved. I know that HCFA has a major initiative to move aggressively and try to get all claims processed electronically.

Mr. ORTON. Finally, are there any lessons that we could learn from the way the Canadian Government pays physicians and the way HCFA pays physicians under medicare?

Ms. SHIKLES. Certainly a couple of things, I guess.

The Canadian Government is actually coming to see us to see how we pay hospitals, because they feel that the budgeting approach that they have taken in paying global budgets does not give them the kinds of incentives and information they need to make sure that they are rewarding adequately hospitals with a sicker mix of patients. So they do not feel they have the data they need and are coming to medicare to look at their hospital payment system.

On the other hand, Secretary Sullivan had some task force in place with insurance representatives in medicare and others to try to move towards administrative simplification which we strongly endorse which would look like the Canadian system—a single card, a set form, standardized billing procedures that would give you incredible efficiency and would also reduce fraud and abuse.

Mr. ORTON. Thank you.

Mr. Chairman, I have used my time, but if we have a second round I have other questions I would like to ask or submit them for writing.

Chairman SABO. Mr. Kasich?

Mr. KASICH. Thank you, Mr. Chairman.

Ms. Shikles, I have learned more about health care serving on the Armed Services Committee than I have on the Budget Committee. I said that yesterday to Mrs. Clinton. I say that because I watched an Armed Services Committee function with great ineffi-

ciency and reward the wrong things—cost plus in Defense an awful lot like cost plus in health care.

I would have to tell you that if you were to ask defense contractors who their best friends are among Republicans, I would be last on the list, because I did not get along with Defense contractors because I thought they were out of control.

And I guess when I first went on the committee, I was under the view that if we just passed a bunch of rules and regulations and had more auditors, that would take care of it, and maybe that is part of the answer, and part of what we have done has worked there.

But I have always been interested in the other side of it which is give somebody a fixed-price contract; tell them what the job is; tell them what the outline is; give them a chunk of money; and let them go to work; and stay out of their hair if they do not fowl it up.

I get concerned when I hear about management plans and all these things that the government is going to do. I guess the reason we have waste, fraud and abuse in the government is there is no incentive not to have it, because we are spending other people's money.

And what we are talking about here is essentially becoming convinced that the government somehow can clean this up. I am not convinced that the government can. I am not convinced that when 4 o'clock comes around down at HCFA that the bureaucrats are not—and I do not mean really to be critical of them, I think it is the system that beats them down—but when 4 o'clock comes, they are thinking about getting ready to go home.

And the reason I say that I am convinced of it is because I had personal experiences in it when dealing with the Welfare Department in one of the counties that I represent. I would call down late in the afternoon trying to get somebody some emergency help, only to have people hang up the phone on me. Then the county commissioners tell me they cannot get rid of them anyway because it costs too much to do that. So we just have to live with it.

I guess my sense is that we have a medicare system that is designed to catch crooked doctors, essentially. We've created a big system and we have one crooked doctor out of 100, but we audit 100 in hopes of finding the one crooked one, and I am not convinced that we ever do. And all we do is create a lot of regulation, a lot of paperwork, and we have not solved this problem.

Medicare has been in existence since 1965. There has been report year after year after year about this kind of waste, fraud and abuse and nothing gets done about it.

I wonder if we need to start thinking in a more revolutionary way about how we should manage medicare; somehow try to move it towards the private sector; somehow involve outside private sector operations in terms of monitoring public sector activity.

I wonder if you have given any consideration to breaking the model and developing a more bold, innovative, private sector approach towards managing this problem as opposed to putting an auditor in every doctor and every hospital in America. That is one way to do it.

But I do not think we are about to do it. I am not sure even by doing that would work. It seems to me that in the Defense industry, we have made more gains by having fixed-price contracts than we did having cost-plus contracts with an auditor in every plant. You know, in the Department of Defense we audit every plant, but we were still getting big problems. We only started to solve the problem when we changed the model.

And I guess what I want to know is have you given any thought to how we change that model? I notice Mr. Dowdal reacting and I would like him to comment, as well.

Chairman SABO. Excuse me, if I could add to your question. In my understanding, there are some places in the country where we have been running experiments with HMO's for medicare which is really using a model that is different than the traditional one, and I am curious in your reports whether you have looked at them and if you find differences from those to the traditional fee-for-service process?

Ms. SHIKLES. First, I think your points are very well taken and we are certainly not advocating an auditor to check out every doctor and we are very interested in figuring out ways to work much smarter and in a much less regulatory way and medicare needs significant help right now because it is frustrating the honest providers. It is frustrating beneficiaries. And in this chaos and frustration, the small number of people who are dishonest are really able to walk away with a lot of money.

Now one of the questions is how medicare is currently operated? And it actually operates, it contracts all these activities to private insurers. So your background with Defense contractors is very relevant. What you have is a bureaucracy in HCFA with not that many people and they lose their leadership, so the difference in a private company is they go a year, a couple of years ago, without an administrator. They are now without an administrator, so you have a set of public officials out in Baltimore running this program. It is contracted through about 80 private insurers scattered around the country and they do work according to a contract.

What we need to figure out is either how to give them incentives to do a better job, because they do not do a great job, and it is hard to figure out whether they just do not do a great job or HCFA has not given them better direction.

I will give you a quick example. We visited 17 hospitals in this area about a year ago and found every one of these hospitals—and the Inspector General later did this study nationally and found the same thing we did—every hospital we went to owed money to medicare. Now this is just simple stuff, but it is a lot of money. And we said, boy do you owe money to medicare. They said, well we tried to send it back to the contractors and they did not take it back.

So we went to the contractors and they said, well we do not have staff to take it back. They do not pay us to take the money back. If we make duplicate payments—I mean it is not in their contract. They operate according to what they are told to do.

So it is mind boggling that you do not have anybody kind of caring about the program and you need to figure out a way to get——

Mr. KASICH. So we have a program that is not based on profit? In other words, if you are a collection agency for a student loan, you collect so much; you make so much money. We do not have this contract designed that way. Who designs the contract?

Ms. SHIKLES. I think it was set up at HCFA. I think some people in the past have considered and I think the contractors would like a percentage to manage to. The physicians and hospitals and labs have all protested vehemently that it would come out of their pockets and they, I think, have kept the efforts from moving forward.

Mr. DOWDAL. Getting back to your original question, it depends on what you are addressing. And I think you are addressing two issues. One is administration. Medicare, the part we are talking about, is the fee-for-service part of medicare. And medicare probably does as well, if not better than private insurance companies do and they use private insurance companies to actually run the program and they have more incentives to do stuff than they do under private insurance plans.

The second part is whether fee-for-service is the best way to have a health program. And there are arguments for and against that versus using HMO's or some other kind of managed care. Medicare does a lot of the things that managed care does—utilization review functions, trying to make sure the rates are not too high like PPO kind of stuff and that, and a lot of that is already built into it. A lot of the stuff that managed care companies do is extracted from the medicare program where it was done first.

But there is still, as we said, there is still a lot of problems with it. When you go to HMO's and look at them, they have an entirely different set of incentives which can lead to an entirely different set of problems. You go from worry about too much utilization under fee-for-service to not enough utilization under capitation payment systems because the providers have incentives to hold down the amount of care and you are concerned about whether or not they hold it down too much.

So you are trading one set of concerns for another and it is a value judgment, which one you think is the one that you want to deal with.

Mr. KASICH. Let me ask Ms. Shikles one final question and I guess I would say to Mr. Dowdal that I am always amazed at people in Washington. We get on the first tee and hit the first 10 balls out of bounds and instead of correcting ourselves, we say, well I better not change my stance because I might hit another one out of bounds and we hit 10 more out of bounds and congratulate ourselves on how good our golf game is. I am for changing my stance when I hit 10 balls out of bounds.

Ms. Shikles, recognizing the fact that this is a mess which is basically what you have outlined here, can we not figure it out by paying for it within the current budget? Let us just get rid of those things that do not work and shift the resources away from them into the things that can work. Why do we have to have more spending? Let us just get rid of that that is not functioning very well.

Ms. SHIKLES. You first have to figure out what—I do not know how to appropriately answer your question. I think what you would like to do is ask the new HCFA administrator to really manage

this program. And I know that sounds like a bureaucratic word, but you could set outcomes that you want achieved and we have never demanded anything of these contractors. So this is different from saying we want to audit every claim that goes out.

Let us take these contractors which they have done on a demonstration and look at performance and award them based on performance. And we have been looking at that for this committee at three contractors that got a little additional money and flexibility to do whatever they thought made sense to try to get a handle on the program. And we have seen some amazing results. We would like to see strategies like that elevated to the level of the HCFA administrator and applied across the board. Some new thinking.

So we are not talking about hoards of staff and the same old thing. We are saying, we want high level attention to this issue. It has been a long-standing problem, as you have said. Do some new things: pay for performance; get rid of the guys who are not performing. Just take some aggressive action. We have not seen that in the past.

Mr. ORTON. [Presiding.] Mr. Pomeroy is next.

Mr. POMEROY. I would like to follow up on some intriguing issues raised by the preceding questioner on the relative efficiencies of public versus private sector. What is the relative overhead of the medicare program relative to claims paid?

Ms. SHIKLES. It is very low. It is——

Mr. DOWDAL. Less than 3 percent.

Ms. SHIKLES. Right.

Mr. POMEROY. Less than 3 percent. What is the overhead commonly found in the private insurance sector?

Mr. DOWDAL. Large. Insurers, the last numbers I remember are in the large ones that we would assume would be more efficient are in the 7 percent, 8 percent range. Most of them include marketing cost which medicare does not incur, but they are still high.

Mr. POMEROY. But it is a portion of premium paid by the policyholders.

Ms. SHIKLES. That is right.

Mr. POMEROY. So actually the 7 percent to 8 percent for administrative functions for the large, most efficient, does not count marketing fees. Is it not true that if you count marketing fees, it is not uncommon to find a potential 40 percent of the premium dollar going to administrative overhead?

Ms. SHIKLES. That is right. Medicare is the most efficient of the insurers.

Mr. POMEROY. The issue is whether or not a further deregulated approach to claims' payment might be our way out of the situation we find ourselves in. It seems to be contravened by the fact that your statement indicates we have reduced funding of the safeguards of improper claims' payment 24 percent in the administration of the medicare program since 1989; is that correct?

Ms. SHIKLES. That is right.

Mr. POMEROY. Do you have an evaluation as to whether improper claims' funding has increased or decreased during that time?

Ms. SHIKLES. We think that it has probably increased and work by the Inspector General and even OMB have raised concerns

about the fact that inadequate funding is really resulting in unnecessary medicare expenditures.

Mr. POMEROY. In fact, I believe your statement indicates that there is a fairly well documented 12 to 1 return proven. For every dollar invested, $12 in savings has accrued?

Ms. SHIKLES. Right. If I give the impression that we think that this program should be deregulated, that is not an accurate impression. We just feel that it should be managed better.

Mr. POMEROY. You would actually favor more activity in attempting to police improper billings and greater standards for our contractors administering the medicare program in order to try and clamp down on improper claims' payments?

Ms. SHIKLES. Absolutely.

Mr. ORTON. Mr. Pomeroy, could I just add to your one question?

Mr. POMEROY. Sure.

Mr. ORTON. On the $12 of savings for every dollar of administrative costs, how did you arrive at that?

Ms. SHIKLES. These are not our estimates. These are really prepared by the Health Care Financing Administration and it is based dollars that they recover from collecting over-payments that were made inappropriately or screens in place or it is recoveries. It is actual dollars.

Mr. ORTON. But these are figures submitted by HCFA?

Ms. SHIKLES. That is right. And they have to go through the Office of Management and Budget. And they have also been looked at by the Inspector General.

Mr. ORTON. Did you have an additional comment?

Mr. DOWDAL. No, I was just trying to say that it is basically the difference—how they figure that out is they look at the amount of savings that they can identify from the activities such as denied claims from the edits that we are talking about. It includes money that is saved by auditing; providers that are paid on a cost basis, to make sure their costs are reasonable; recoveries from other insurers or avoidance—it is only recoveries, I believe—amounts that other insurers should have paid when medicare paid first.

And then they take that and compare that with the amount that was spent on those activities, and that is where the 12 to 1 ratio comes from.

Mr. ORTON. Did you have an additional question?

Mr. POMEROY. For the record, I would note that I worked closely with Ms. Shikles in my prior capacity as an insurance commissioner and officer in the National Association of Insurance Commissioners and the GAO staff as well. I look forward to working with you in my new capacity as well.

Ms. SHIKLES. Thank you very much.

Chairman SABO. [Presiding.] Thank you, Mr. Pomeroy.

Mr. McMillan?

Mr. MCMILLAN. Thank you.

I think we are dealing in many ways with a system that creates wrong incentives and that is a lot of our problem. Along the question of audits, it struck me that most of the private sector operates on spot audits. I have spent 20 years in the business world. The object of an audit is not necessarily to generate revenue. You do not measure it in terms of what it generates on a 1 to 12 basis or

whatever. The purpose of an audit is to serve as a preventive and that we might get a lot higher returns if the penalties for fraud were far greater than they are and that those penalties perhaps should not be financial, but should be even more drastic.

I like to think that basically both in the private and the public sector we operate what I call an adversarial claim system and we operate as if every claim is an attempted fraud. Basically we ought to operate on the opposite grounds, and assume that most people are honest when we conduct spot audits. And when they are not, if it is a doctor, he loses his license; if it is a patient, they lose their benefits.

The penalties may sound severe, but I think that would then reduce the activity. Whereas, now what we do simply becomes a game and the penalties are not that great and we expend enormous amounts of money playing the game.

You talk about the administrative costs in here and I do not think it is quite valid to compare what you use as a 4 percent or 3 percent figure for medicare with what maybe the private sector does. I have heard testimony in Energy and Commerce Committee from some of you and also from the private sector. Some insurance companies are down in the 4 percent range on administrative costs. I think we could probably manage that down a lot better.

From my own perception of trying to file claims on private insurance, there is an enormous cost taking place in paying those claims that is just unbelievable. A lot of it has to do with the fact that we have created a system that puts the incentives in the wrong place. Companies are trying to make money by delaying payment of claims or denying payment of claims or through obfuscation and I think a lot of that goes on in the public sector as well.

When in fact, it ought to be pretty darn clear cut. We ought to define in clear terms what we are going to reimburse; what standards of practice are in a given situation and pay it quickly without question. Then we should follow through with spot audits that when the system is violated, the penalties are strong. I just state that and if you care to comment on that, I would be glad to hear it.

Ms. SHIKLES. I think what you say is right. Unfortunately, these are the strategies that the medicare program has tried for some time. To do audits which are necessary, it takes staff. They are very costly and they really had a cutback in staff, so they will be doing many fewer audits this year. But the problem with the audits is that even when you find someone who has ripped off the program, so to speak, it takes forever to try to get this physician or laboratory out of the system or to get any of the money back. So insurers, both public and private, are very discouraged about the disincentives. So people are beginning to think that we need new strategies. We have to find a way to not pay that bill in the first place, because it is so difficult and expensive to ever get the money back.

Mr. MCMILLAN. You know what you do in business, you do not pay the next bill. We do not get hung up on the last one, you have got a stream of payments going to any one of these providers.

Ms. SHIKLES. No. You know what the problem is, that worked when most of health care, most of expensive health care was in hospitals. But what is happening and what these contractors are

faced with is everything is moving out of a hospital and you are getting billed by corporations that might have 30 different corporate names, different ID's, different billing numbers, and the minute you catch them, they disappear. There is no money to recover.

Mr. McMillan. I have cosponsored legislation to get a consolidated billing system where everybody has got a number and there is a central clearinghouse.

Ms. Shikles. That would help tremendously.

Mr. McMillan. I think that would simplify things. Payment ought to be immediately and the questions asked later. I think that is a big incentive to the care providers out there to cooperate in installing such a system.

Ms. Shikles. Absolutely. What we think would help medicare tremendously, as well as private insurers in paying people quickly and also protecting these public and private insurers from inappropriate payments is moving towards administrative simplification with one billing number, a standard form, and a set of other activities. Because what happens now is, and we see this a lot in medicare and private insurers too, is these guys are able to run behind a lot of different names and numbers. So it is very hard to sort out who is billing you.

Mr. McMillan. I have some personal comments on ambulance service with an 89 year old mother who is in a skilled nursing facility and has been in and out of the hospital recently. If a person in such a facility falls out of their chair, they will call an ambulance; send them to the doctor's office to have an examination because there are no doctors on the premises. She is in a good facility and I do not get reimbursed. I mean that kind of use of ambulance service just compounds. But no one is engaged in total managed care in that situation.

Getting back to the incentives. We have got the insurance companies which you say are contractors, but basically we are setting the terms of the contract. They do not have any incentive to really manage the whole process.

Ms. Shikles. That is right, exactly.

Mr. McMillan. They are piggy-backing us and they are piggy-backing the patients and trying to make money in a confined playing field or break even. That does not give them a chance to deal with the total problem. In many ways, I think government is over-defining its responsibility and we are on the—this is no criticism of you, because you are doing what you are asked to do—but government generally over-defines its responsibility and we are on the verge perhaps of raising the ante on that. I am not sure that we will improve the situation in so doing.

I would rather see us pursue a system that tries to define what we mean by acceptable levels of health care.

Mr. Orton. Do you have a brief response and then we will move on?

Ms. Shikles. I do not have a response.

Mr. McMillan. I did not complete the question. I would not expect one.

Mr. Orton. Would you like to complete the question?

Mr. McMillan. It will be real quick. If you get a chance later, and that is basically by defining the level of care that you expect government to provide. Why not use a voucher system that basically pays for that in the case of a person who cannot afford it and then scale down by income level? Then you basically let the delivery system through competition provide that service and at the same time the patient gets into the decision-making on that.

But if you get a chance to comment on a voucher system, I would be interested in hearing your comments.

Mr. Orton. If you would like to comment at this point, go ahead.

Ms. Shikles. I think I need to learn more about what your proposal is before I could respond.

Mr. McMillan. It is a comprehensive contract for managed health care in effect.

Ms. Shikles. That the individual would buy into some type of company that would negotiate on their behalf for services; is that it?

Mr. McMillan. It would basically require every insurance company to provide basic care coverage and a voucher would be sufficient to pay for that. Then it would be scaled down by income level across the spectrum and you would basically merge medicare and medicaid and any other Federal assistance into a similar program. That voucher could be used to buy an insurance policy. It could be used to buy ån HMO contract.

Ms. Shikles. I think that is certainly worth considering. We certainly have problems in the medicare program that would want to make you look at other ideas.

Mr. Orton. Thank you.

Mr. Gordon?

Mr. Gordon. This is a very important panel today, if we are going to get a handle on our deficit problems. Like many, I had another meeting so I came in late and I am going to have to leave too early, so I apologize for that. And I do not mean to trivialize your testimony. But basically what you are saying is, depending on where you read, you save $11 or $12 for every $1 in cost controls?

Ms. Shikles. Yes.

Mr. Gordon. And you say that we need an administrator that is going to do a better job. Now let us assume that you are that administrator.

Ms. Shikles. Okay.

Mr. Gordon. No one knows more about the program, I guess than you do now. So what are some specifics? You mentioned here the standard billing forms. What can be done? What changes would you make in the program to make it more efficient?

Ms. Shikles. You are looking at a program that, as you know, costing about $120 billion this year and we are looking to having it double by 1998. Not all of that money is going for appropriate needed services by the elderly. There is a tremendous amount of waste and unnecessary spending that in no way helps anybody. And we need to get a handle on it, particularly on Part B which is contributing to such deficit problems.

If I was the HCFA administrator, there are some very specific things that I would do right away that I think you would be surprised are not done now. Payment safeguard activities, which

really means where we are spending the money and what are we spending it for, is a buried activity in the agency. I would elevate it. I would probably put somebody very senior in charge and ask them to come up with a plan that I could implement within the month perhaps on a set of things.

First, I would want the contractors—I would want to know if I have the computer data capability to generate interactive trends data. If you go to many of the managed care companies, what do they do? They are vouched in their company. What they are vouching is what they are spending their money on and if there are changes, because that is a sign that you might have a problem. If all of a sudden you have this tremendous increase in ambulance services, what is going on?

So that is just basic data to manage the program. What is going on and you do not have that now. You cannot go out to a contractor and visit the contractor and say, where is the money going for the different services and how has that changed since last year? That is just a very basic question. So that is just basic management data.

Number two, I think that you need to do a quick assessment of where is the program vulnerable? Where do we need national medical screens that are fair, that you could tell the physicians, tell the providers, you follow these rules, you get paid quickly. You do not follow these rules, you are not going to get paid. This is very simple, but it is not done and it is not standardized.

To get back, be sure that you have the policies that you need, the screens that you need, and make sure the contractors meet. They do not even meet that often. Maybe they should meet weekly. I mean I am the manager of staff—it just seems like these are basic management tools. And I know it sounds mushy when you testify, until you get out there and see that some basic things are not done.

Number three, I would come back to you and ask you to pass some legislation. The program is vulnerable to a set of weaknesses that just need to be changed. Otherwise, you have to put auditors chasing after these guys. When if you passed a few legislative changes, then the honest providers would get billed quickly. They would not be hassled. But you would not have all these weaknesses.

One of them is telemarketing. I do not think there is any place for telemarketing in the medical field. Where you have a fraud scam, you always find somebody doing this cold calling, hustling to buy equipment. They usually go to the beneficiaries and they end up getting the beneficiary's number—it is back to another Congressman who said, let us have penalties. Let us have penalties if you do telemarketing in the medical field.

So there is a set of legislative changes that you could pass that I think would have total support of the provider community that would get a lot of stuff out of the system. Then I think we need to start doing some smarter—we ought to work smarter. For example, if you visit a PPO, a preferred provider organization, one of the things they do is they get a panel of physicians and they do constant profiling. And every day they look at the physician's practice and they adjust for a patient mix. So if the physician orders a lot of tests, they want to know if that physician has sicker patients, more AIDS' patients. And then they adjust for that.

But they want to know how many tests—the physician in health care is key. The physician is the one ordering the tests, the MRI's, the CT scanners, the radiation treatment. So all of your spending is being driven by the physicians. So you want to look at your panel of physicians to see what kind of services they are ordering and how do they compare to their colleagues.

What a PPO will do is if it is inappropriate and they are so out of line with other physicians, then they will give them a couple warnings and then they will be out of the system. I think these are the kinds of things that you need to look at in medicare, because we cannot afford to constantly have all these auditors and we are hassling physicians. I think we need to have some up front smarter strategies that we could put in place pretty quickly that would start getting spending under control and begin to get at some of our concerns. All of these things are going on right now and I could go on.

Mr. GORDON. Do you have something written? Is there a report to this effect?

Ms. SHIKLES. We are in the process of working on a report that would lay some of these—we have issued previous reports with some specific legislation/recommendations. We will be issuing for this committee a report that lays out a set of these recommendations this summer.

Mr. GORDON. Will they include the things you just mentioned?

Ms. SHIKLES. Yes.

Mr. GORDON. Is there a way prior to this summer—if we just get them this summer, then we are talking about next year to do anything. Is there a way that we might be able to get some of these recommendations?

Ms. SHIKLES. Yes, we could get them to you sooner.

Mr. GORDON. A rough draft.

Ms. SHIKLES. Certainly. We could get them. We have a long list.

Mr. GORDON. Again, not to hold you to it and not to be critical in any way, but only to seek your help as an expert.

Ms. SHIKLES. Right, absolutely.

Mr. GORDON. My name is Bart Gordon and I would appreciate that.

Ms. SHIKLES. We will get them to you.

Mr. GORDON. Thank you very much.

Chairman SABO. Mr. Miller?

Mr. MILLER. Thank you, Mr. Chairman.

Just a couple of clarification questions. I am still learning all of this system, of course. You say it is 3 percent administrative cost for medicare on the $120 billion?

Ms. SHIKLES. That is right.

Mr. MILLER. And then $1.6 billion goes to contractors and the balance goes to?

Mr. DOWDAL. The 3 percent covers the contractors; it covers HCFA's own employees. There is money in there for the Treasury Department for its collection of the medicare taxes. And there is a number of other things that get built into the amount, but the total administrative cost is about 3 percent. The contractor budget is just a little bit over 1 percent.

Mr. MILLER. You say you have 700 million claims a year under our fee——

Ms. SHIKLES. That is right.

Mr. MILLER. What are the projections, if we went to the managed competition or the HMO? There is going to be a dramatic change in claims, I guess? It is a whole different ball game.

Ms. SHIKLES. Right.

Mr. MILLER. But what is it? Do you do studies along these lines or are those around?

Mr. DOWDAL. Theoretically if you had everyone in an HMO, since medicare has 35 million patients, you would get 35 million bills a month or capitation payment times 12, whatever that is.

Ms. SHIKLES. Yes, because you would just be paying the HMO a monthly payment for each beneficiary, so you would totally get rid of all these different claims which are all for different services.

Mr. MILLER. Mr. McMillan was asking about the standardized claim forms. I thought that was in the works. Is there one being developed by HCFA now? I thought Secretary Sullivan last year——

Ms. SHIKLES. Secretary Sullivan set up several committees. Congressman Pomeroy, were you involved in that? I do not know if you were involved in the standardization—the Secretary set up several committees, but I think they are just voluntary and they have proposals to move forward and they included representatives of State insurance offices and public and private payers and private insurers. But I do not think they are in any legislative language yet.

Mr. DOWDAL. There are standard billing forms ready for both physicians and for hospitals and medicare and medicaid both use those forms and many of the insurers also use those forms. But there is no requirement that everyone use those forms. We have many private insurers that use a different form. The basic forms have already been designed and are in place and are being used by a number of people. The idea is if we get everybody to use those forms, then you eliminate having to worry about the claims' clerk having to worry about whether they have got the right form and the differences in the way they are filled out, because everybody will be getting them.

Mr. MILLER. Is there a state of the art behind this whole process, as far as computerization of this whole process? I mean how far behind state of the art are you?

Mr. DOWDAL. This stuff can be all be put on—if you have a standardized form——

Mr. MILLER. The entire medicare administration.

Mr. DOWDAL. You can put it on a PC and have a billing clerk fill it all out and that can then get transmitted electronically to medicare and medicare can have electronic fund transferred to the provider's bank and they can also electronically remit back to the provider what their disposition was.

Mr. MILLER. My last question is how far along are you—on a scale of 1 to 10, 10 being the most sophisticated computerization claim system versus one being the worse—how far along would you put the government system?

Mr. DOWDAL. Medicare has all of those capabilities, not necessarily the greatest ones and they are all not used by everyone.

Mr. MILLER. That is not a problem though, the computerization?

Ms. SHIKLES. I think it is a problem.

Mr. DOWDAL. They are currently working on designing a better overall system. There are a bunch of different systems that are capable of doing this. They are trying to define a more uniform system.

Ms. SHIKLES. But it is a problem. Although medicare, I think is ahead of the private insurers in terms of moving towards electronic processing, and payment safeguards. It is behind in terms of the kinds of computer systems it needs to do the analysis it needs.

Mr. MILLER. Thank you.

Chairman SABO. Mrs. Mink?

Mrs. MINK. Thank you, Mr. Chairman.

I also want to apologize for coming in late. So you might have covered this in your preliminary comments. But I have been taken by reports, news accounts and your document here and it speaks to the high risk for fraud and abuse. I wonder if you could explain to me at what level in the medicare program does this high risk for fraud and abuse exist? Is it at the level of the beneficiaries? Is it at the level of the health providers? Is it at the level of the contractors? Where is this high risk?

Ms. SHIKLES. It is at the level of the provider. And the way it works is that medicare contracts today with about 80 private insurers who are located around the country who are responsible for paying all these claims that come in for different services. Most of those claims are legitimate from legitimate providers for services they really provided.

A set of those claims that come in are not legitimate. They are either services that were not provided. They were services that were unnecessary. They split the code. They split the claim, the service they provided and billed many times. They have charged for things that are inappropriate. All the kinds of scams you might imagine. It is a small percentage of the providers participating in medicare, but because of the dollars involved, it can rack up a big amount.

But it is really coming from the provider community and it is everyone. It is doctors and it is labs and every type of provider billing the program.

Mrs. MINK. How did you arrive at this conclusion in your report? What evidence is there in the reporting or in the documentation that you saw or whatever that led you to the conclusion that this program is a high risk for fraud and abuse? Is it the incidents of people that were caught and found and the percentage of that incidence as compared to the outstanding claims? Or how did you arrive at that conclusion?

Ms. SHIKLES. Yes, that is one way, and we and the OMB and the Inspector General's office all have the same concerns and conclusions about the program being at risk. And it is the fact that we do not think the controls are in place to make sure that only those claims that are for legitimate services should be paid.

Mrs. MINK. How——

Ms. SHIKLES. Well you go to a contractor and you begin to look at what they are paying for and then you can pull claims or you get a

tip off from someone that a scam is going on and you go in and investigate it and you find out——

Mrs. MINK. And this does not occur because there are not enough people on the staff of the providers to make this kind of field investigation or to look over the records and make these kinds of judgments? Is that the basic reason?

Ms. SHIKLES. That is part of the problem, but we think the larger problem is the fact that you need to look at what is happening in the program and as you get new procedures being billed, you need to figure out what to develop on medical policy. For example, there was a scam in durable medical equipment last year that this committee did a study of. All of a sudden a contractor started getting billed for seat lift chairs under medicare. And it was probably just a few suppliers, not the whole industry. But a few suppliers did a massive telemarketing campaign; got beneficiary numbers; and all of a sudden whether they needed it or not, they were getting this equipment.

Because the contractor does not monitor what they are spending—they just pay claims as they come in—they did not even know that all of a sudden something that was maybe $50,000 which was probably reasonable, all of a sudden jumps to several millions dollars. They did not even know that. If you were watching what your money was being spent on, you would say, something is going on here. You would call up; you would find out what is the problem. And usually you will get tipped off pretty quickly that you have got a problem. And then you would sit down and say, we need a medical policy in place that sets out the criteria when we will reimburse for this seat lift chair, for example. And then we would put in a computer screen that any time a claim comes in that does not meet these criteria, the claim would be rejected. So it gets it.

What you are talking about is 700 million claims coming in a year. There is no way you could have enough human beings to look at this, so you need to have very sophisticated computer screens and medical policies. You need to inform the provider community what the rules are and just keep on top of it.

Mrs. MINK. What would you estimate as the total losses to this program on account of the fraud and abuse and the lack of control?

Ms. SHIKLES. No one has ever done an estimate and it is hard to estimate because fraud abuse is obviously a hidden activity. We did a study last year looking at the whole health insurance industry, and after talking to every expert in our own work and the work of others, felt that 10 percent of health care in spending in general is probably fraud and abuse. Most of this is abuse, rather than fraud.

We have just recently been working with about 11 contractors and they would think that 10 percent is not unreasonable. So on the Part B side which is about $52 million, I think this year, you are talking about several billion dollars going to unnecessary services.

Mrs. MINK. Is it larger on the physician services under Part B as against the hospital, Part A?

Ms. SHIKLES. I do not know. There is more control on the hospital side and then the hospital is an entity that stays put. If you find a problem in overpayment or in unnecessary payment, the medicare contractor offsets the payment the next month. The problem on the

outpatient side and where all of health care is moving to the outpatient side, is that typically you are getting billed from often unregulated facilities, facilities that do not have any assets. If medicare finds that it has made an inappropriate payment, there is often no money there to recover. So it is money lost.

Mr. POMEROY. [Presiding.] Congressman Allard?

Mr. ALLARD. Sorry I missed your testimony earlier. I would apologize if I ask any repeat questions. I hope I do not, but you talked about under funding as a main problem for HCFA. How much do you think they need for their investigations?

Ms. SHIKLES. We feel it is a funding problem in management.

Mr. ALLARD. Let us start it this way. How much are they spending now for investigative work?

Ms. SHIKLES. This year they are spending about $400 million for payment safeguard activities.

Mr. ALLARD. How much more do you think they need to do an adequate job?

Ms. SHIKLES. We do not know exactly how much more. We are concerned that they might be cut, given the current budget situation. In visiting contractors recently, we are finding that just standard screens that I talked about, if you run a computer screen and you pick up a problem, most of that $400 million goes to reviewers, like nurse reviewers who review the claims, or do the medical audit. We are finding that there are not sufficient staff out there to review the claims that are being suspended because they are suspect for some reason.

I cannot give you a precise number. I think that some additional funding, certainly stable funding and some additional funding to try to make sure there is adequate staff to review these claims. That would be in conjunction with a plan that we would like to see HCFA put together perhaps and present to Congress, so that you will get a better handle on this. This has never been done.

Mr. ALLARD. So you cannot even give me a ball park figure?

Mr. STROPKO. I think 10 to 12 percent would be appropriate. That would allow them to at least maintain their level of effort, because claims themselves grow at 10 to 12 percent a year. So what we are seeing is essentially a declining effort every year because the funding has been more or less stable; the claims are increasing which means they just look at a lower percentage of claims. Thus, a 10 to 12 percent increase would be a minimum to allow contractors to maintain their level of effort.

I do not think you would want to put a whole lot of money up there up front, because we do think that the program can be considerably better managed. And it takes time to put these things in place and to train staff. I think a reasonable first cut would be 10 or 12 percent and I think you would get a much, much greater return than your investment. And I think you would get 10 to 12 times the return on your investment, because historically for the last 10 to 15 years, medicare has seen returns of 10 times or better for its investment in this area, and the program has spent much more in the past.

Mr. ALLARD. You say you are getting about 700 million claims a year; is that right?

Ms. SHIKLES. That is right.

Mr. ALLARD. It seems like I saw somewhere or I am under the impression that there is a requirement that you file a claim daily. You do not have to do that, so if a patient comes in say 3 days in a row for treatment in an office, for example, that doctor could compile that and put that in one claim and would not have to do that on a daily basis?

Ms. SHIKLES. That is right.

Mr. DOWDAL. If you were in the hospital, for example, for 10 days and the doctor sees you, each day that you are in the hospital he can send in one claim form with the 10 visits on it. He does not have to send in 10 separate ones.

Mr. ALLARD. Are there areas that we can eliminate record keeping so that you can make it simpler to audit, more easier to track?

Mr. STROPKO. I do not really think so. Actually it gets a little harder to track with electronic claims. These claims are less expensive to process, but you lose a paper trail which always makes auditors a little uncomfortable. It is a labor intensive process. You have to pull a claim; you have to look at a medical record; and you have to see if what the provider claims was done; was done; and was appropriate under the circumstances. And that takes a person to spend a few hours with some paper copies.

Mr. ALLARD. I hear so many complaints from the practitioner about the amount of paperwork. I think I can see that. I can think of some doctor's office I was in 20 years ago and maybe he had one secretary or two secretaries in the office. Now they have five or six and the same number of physicians. It seems to me that there ought to be some way to reduce some of that paperwork.

Ms. SHIKLES. I think that is one thing Congress could consider that would help medicare and private insurers. I think that if Congress took some of the suggestions that were set up by Secretary Sullivan and some of their reports and could move ahead on passing administrative simplification, for example, that helps. It would make life easier certainly for providers. They could go back to a more standardized form that everyone used—a smart card for a patient, for example. It helps medicare and the private insurers. One billing number which then really cuts out a lot of fraudulent activities. Because that is how a lot of the scams are operating now. They are able to hide under a lot of different billing numbers.

Mr. ALLARD. Thank you, very much.

Thank you, Mr. Chairman.

Chairman SABO. [Presiding.] Mr. Stenholm?

Mr. STENHOLM. Would you talk a little bit more about what you mean by administrative simplification?

Ms. SHIKLES. Well, administrative simplification generally means moving towards some types of standardization. And there are some committees set up by Secretary Sullivan who met last spring and this summer and they have actually come out with some reports and some recommendations of the feasibility of putting it in place.

Mr. STENHOLM. Are there savings associated with that?

Ms. SHIKLES. Pardon me?

Mr. STENHOLM. Are there savings that have been identified to be associated with that?

Ms. SHIKLES. Yes. I think they estimated something like $5 to $10 billion.

Mr. STENHOLM. Billion?

Ms. SHIKLES. Yes, for the whole insurance industry—both the public and private payers. Because you would be moving towards one card, one form, trying to simplify the rules. And I am not certain if those savings include the reduction in billing clerks that you might be able to get away with.

Mr. STENHOLM. This last week, I had my latest complaint from a constituent at a small rural hospital. During the month of January they had 11 different investigators, regulators of different types in their hospital. That was more patients than they had in the hospital during that month. That rhetoric suggests that we may go a little overboard in checking and rechecking some people. And yet you then come in and suggest that we could have a greater dollar return by providing more investigators. I, too, apologize for not being here for your entire statement and do not want you to repeat if you have already addressed this issue.

But I am hoping that if you are suggesting additional people to check, which pays dividends by catching fraud and waste, that you are also identifying some places where we might eliminate some people and transfer others, so we are not adding on to this paperwork burden that we all get complaints about.

Ms. SHIKLES. We get complaints daily too. I do not know who the 11 regulators who went into this small rural hospital. That is surprising to me. But I do not think they would be medicare regulators.

Mr. STENHOLM. No. I am not suggesting they were all medicare, but I am suggesting that somebody was checking somebody was checking somebody was checking somebody.

Ms. SHIKLES. We understand how burdensome the process is now for the honest provider who is trying to deliver services and is burdened by complex forms, and we are in no way trying to add to that burden. We are concerned about it too and we are not recommending more auditors to go out and check every bill that comes in.

We are saying that we have a system that was set up in 1965 when the health care practice was very different than it is today. We also are overlaying the system with a computerization. We are moving towards electronic processing. We are still learning with this old decentralized system which may be appropriate, but we are not using some of the latest management tools. And there are tools you can put in place that are not sending 11 people out to harass the small rural hospital.

There are some sophisticated computer edits that managed care companies use, for example, that try to set out up front what you pay for and what you will not pay for. You let everyone know the rules and you prevent overpayments to those people who are trying to scam you. It is pretty quick. It is pretty simple. But you have got to have the management rule at the Department of Health Care and Financing Administration to put the rules in place.

This does not mean a big bureaucracy. These are just simple, efficient tools that we think could change how you run the program and save a lot of money that we are spending unnecessarily. You would get no letters from beneficiaries saying they were not getting services they needed.

Mr. STENHOLM. I certainly concur with the general thesis of what you just said. Within the managed competition bill that we are very supportive of in the way of health care reform, we think this is a critical component. And that is why we are very interested in what you have identified as simplified management or management simplification.

Thank you.

Chairman SABO. Ms. Snowe?

Ms. SNOWE. Thank you, Mr. Chairman.

I certainly appreciate your testimony here today. It is, I think, quite compelling in a lot of instances. I know, too, as the gentleman from Texas was saying, about people who have been victimized by the system in the processing of claims. That is not only a complex process, but the delays are ad infinitum. It can go from 6 months to a year before contractors are reimbursed. I know I have visited medical equipment companies that have had constant delays in that process, so there is something clearly wrong.

On the other end of the spectrum, of course, is to try to address the abuse issue. I was interested in your suggestion on scoring. If we were to increase funding for administrative staff to provide for more safeguards in the system, but somehow there is a scoring for the savings that will occur, and not having to have a commensurate reduction in spending in other programs. I think that would provide more incentive here in Congress, as well, to look at those issues. Similarly to how we deal, as you mentioned, with the IRS.

I listened with interest this morning to Dr. Reischauer's testimony because he did mention the issue in talking about the increases in medicare and medicaid over the last 20 years. When he was asked about the issues of fraud, waste and abuse, he said he had no indication of the extent of it or how much. And I thought that was interesting.

When you have a program of $120 billion, it is clear to me that there is going to be some element of fraud, waste and abuse in that program. So we should be connecting on those issues and I think there would be more incentive to address this problem which clearly is pervasive.

What I would like to ask you is what role really do the insurers play in all of this? I know they process the claims and everything, but do they have a tremendous responsibility in providing for the safeguards? I mean, obviously, they are experienced in these issues. Could they not provide a level of assistance or does all the guidance and dictates come from HCFA?

Ms. SHIKLES. I think they could provide a lot of assistance. That is why I think that the program was set up that way back in 1965 that they thought, rather than having the government run it, which often has problems, you would contract with these private insurers that had experience in their private business in running the program. I think that many of these contractors would have a lot of ideas if you gave them the incentives to really manage the program and then you manage to make sure they did it.

Now they kind of get a report card and what the report card talks about it is not a management type of system. It is really how fast did you pay a claim; how fast did you answer the phone. It is

not, how appropriate is the payment, or how often are you likely to pay inappropriately?

So now they kind of just do whatever they are told by HCFA. There has been a demonstration that we have been evaluating for this committee where it does not sound that earth shattering, but it was because they gave three contractors a little more money and said kind of go to it. If you were running this on your own, what would you do? And they did some pretty creative things and got quite a considerable savings as a result. And I do not think they hassled anybody any more. I mean, it is just sort of common sense business practices. So I think your point is very well taken.

Ms. SNOWE. I think that it is certainly an issue that we ought to be pursuing.

Ms. SHIKLES. Absolutely.

Ms. SNOWE. I mean this whole issue. It is clear to me that it is a very extensive and a very costly problem. I guess I am as surprised as you are that these basic, simple, management procedures and tools have not been in place long before this.

Ms. SHIKLES. Right.

Ms. SNOWE. Something is clearly wrong.

Ms. SHIKLES. Ed just came back from a couple of contractors and found that these contractors had got this additional money and they put together trend data. So then they found out that all of a sudden they had a surge in ambulance spending. You would think that would be something that you would just automatically know or why would you want to wait 2 years to see that all of a sudden you have this surge in spending, because that might mean that some operator out there is ripping off the system or it is legitimate.

But now they do not even have that kind of data, so years go by and then they sort of say, I think we have a problem here and then you try to go back. And then you find out you did have a problem and then these operators are long gone. So the medicare program is out the money. Then you have to have a lot of auditors trying to retrace it, so it is very labor intensive, very foolish, because you are not going to get any money back.

So with some simple up front management techniques, hopefully you prevent this.

Ms. SNOWE. I know at several town meetings I had this year, it was interesting. I had two different instances in which people indicated they reviewed their bill, only to discover that they were being charged or the government was being charged for procedures that did not actually occur.

Ms. SHIKLES. Right.

Ms. SNOWE. I think we ought to urge all consumers to evaluate their—even if they are not having to pay for them, to evaluate those expenditures, because they can certainly help in that process. And they brought it to the attention of the provider, as well as to HCFA.

Again, I thank you.

Ms. SHIKLES. Thank you.

Chairman SABO. We have a large group plan in our area which has a provision that if a participant finds an overcharge on their hospital bill, the employee gets a certain percentage of it, as an incentive for them to look at their bills.

Mr. Hoke?

Mr. HOKE. Thank you, Mr. Chairman.

I do not know if you covered this earlier, but I wonder what are the penalties when you uncover fraud or abuse on the part of a provider?

Mr. DOWDAL. If you prove fraud or abuse, the penalties are severe. It is 5 years in jail. I believe, the $50,000 fine may have been increased to $200,000. I am not sure. But there is severe penalties, but the problem is, as you probably know, it is very difficult to prove in a court of law beyond a reasonable doubt that someone committed fraud. That is one of the reasons why people can continue doing stuff, because it is so hard to prove fraud.

There are also some of the civil administrative penalties that can be applied. There you do not have to have as high a burden of proof as you do in——

Mr. HOKE. Clear and convincing or just a preponderance?

Mr. DOWDAL. Preponderance, I believe.

Mr. HOKE. Let me develop the question a little bit more. Is it Shikles?

Ms. SHIKLES. Shikles.

Mr. HOKE. Thank you.

Because it seems to me that you were talking about and I think you are saying as much as 10 percent——

Ms. SHIKLES. Right.

Mr. HOKE. Of the dollar volume is because people are cheating?

Ms. SHIKLES. Providing unnecessary services.

Mr. HOKE. Cheating. You have used the word scam, ripoff, con. I think those are those are the words that you used.

Mr. STROPKO. In some cases cheating. In other cases, if you do not have a medical policy, you could take advantage of a system that simply does not have a rule to prevent you from doing what you are doing. So it is not cheating, because there is no rule. It is inappropriate.

Mr. HOKE. But that is easy to solve because then you create the rule administratively very quickly.

Mr. STROPKO. That is easy to do, but one of our complaints about the management of HCFA is there is no central process for looking at the individual carrier rules. Some carriers have good rules, others do not.

Mr. HOKE. Let me go back to the original question which has to do with how can you use—one of the reasons that people do not commit crimes on a daily basis is because there is a deterrent function of the criminal justice system and people know that, at least sometimes. If they commit a crime, they are going to get caught; and if they get caught, they might get convicted; and if they get convicted, they might just get punished, so they tend not to commit crimes.

Is there a lower threshold at an administrative level that does not require the level of proof that is necessary for a criminal conviction that would simply—and I am thinking out loud here—but that would simply proscribe a provider from being in the system? In other words, get them out and that is their punishment and that would be the deterrent.

Ms. SHIKLES. One of the problems in this area is that deterrent effect is not working and that is because if you want to ripoff the system, you know that it is very unlikely that you are going to get caught. And if you get caught, you are probably not going to have to pay any money back and you are probably not going to go to jail or lose your license.

And I can give you a story that we investigated that occurred in Southern California. I do not know if you have heard of the rolling lab scam. This has been going on. It is an interesting case and medicare is involved and about 90 percent of all private insurers in California. It started in the early 1980's. It will illustrate what is going on in health care. Anyway it started in the early 1980's and these are vans that started with senior citizens centers and then began cold calling to health clubs. And one of our own staff got a call from one of these other operations. They invite people to come in and have a battery of tests.

But anyway what they do is they get their health insurance number, and then they bill the medicare program and private insurance for a battery of high cost tests and services that were unnecessary. They get kick backs from other labs. They give kick backs to physicians for referring patients. So you have an operation going on. At the height of this scam, they had about 200 physicians and other providers involved in it. The scam hired some providers by just advertising in the L.A. Times.

The situation here is that actually medicare caught on pretty early, sort of in an odd kind of way and stopped the practice in the medicare program or stopped being billed for it. These operators did not miss a beat though, and moved on and continued to bill other private insurers in California.

Even though private insurers have gotten an $18 million judgment against them, and medicare has a $5 million claim against them, medicare and the private insurers have gotten no money back. The private insurers and medicare invested a lot of resources in this case. It still has as yet to go to trial. Some of these physicians are still practicing in California. This has been going on for over a decade. It is such a big case that it is consumed the State insurance departments, investigative resources and they told our staff that they are aware of other scams going on in Southern California just like it. But because it is so labor intensive, they cannot investigate them till this case goes to trial.

So I think the problem is that the penalties are in place, if you can ever actually catch these guys and take them to trial and act on it.

Mr. HOKE. Obviously, they are not though. They are not in place, because there is no deterrent effect. What you are telling me, in fact, is that it is not working.

Ms. SHIKLES. Right.

Mr. HOKE. It is sort of a sematic argument. Because my time is going to be cut off, I would rather ask you a question: Have you thought about how at an administrative level, rather than waiting for an extremely lengthy process that goes through the criminal justice system or the civil justice system, in which a defendant or a criminal defendant can delay forever or a very long time and it is expensive, how at an administrative level you can simply, regard-

less of what happens with what you know and where you have been taken advantage of already; but going forward those providers, those physicians, those laboratories, those vans or labs on wheels, whatever, are cut out of the system. And then as an administrative matter, you simply notify your thousand third party providers that you contract with that Dr. XYX and Lab XYX are no longer allowed to be reimbursed period?

Ms. SHIKLES. In the medicare program, they have civil penalties that they can get through using the Inspector General's office. So there are actions that they can take that they do not have to go through the long criminal process.

Mr. HOKE. Again, I am not talking about penalties. I am saying, going forward with those—the biggest penalty to somebody that is trying to ripoff the system is to not allow them to do it any longer.

Mr. DOWDAL. There is a whole list of reasons why medicare can throw people out of the program. But they have to follow due process the courts have said. So that still, it is not as simple as just saying we know you did something wrong, so you cannot do it any more. They do do several thousand of those, I believe a year, or at least a thousand or so a year where they exclude people from participation in medicare and medicaid and other Federal health programs. And there is a whole series of things that they can do that for. But again it is not real simple.

Mr. STROPKO. In certain States and we are just becoming aware of this ourselves, in the medicaid program, they view the medicaid provider agreement as a contract that they have a right to unilaterally terminate. It has not been challenged in the courts yet, so it works quite successfully. They just simply say, we do not want to deal with you any more.

Mr. HOKE. I am sure my time is up.

Chairman SABO. Mr. Stenholm?

Mr. STENHOLM. I am not sure if I have a question as much as an observation in light of the last exchange of thoughts and ideas. I am very familiar with our agricultural programs, including Agricultural Stabilization and Conservation Service which is in charge of regulating farm program payments. We have a county elected committee system in which there are peer groups within every county that review what is going on, checking the payments, rates. In this case, the ASCS is about a $17 billion program, which is less than what the medicare program will go up this year. But we are under tremendous scrutiny.

The peer review system works. It works because if a neighbor catches a farmer cheating on their program, they are turned in. There is an investigation. It is by peers. And it seems to work fairly well. Perhaps it doesn't work perfectly, but it seems to work.

I have been thinking along the same lines in the food stamp program of some way to create a local peer review group, where you have people that can better understand what is going on at the local level. I do not know whether it would make any sense whatsoever in this program to assist with making sure people do not cheat.

You say it is difficult to find waste, fraud and abuse. It does not seem to be too difficult to do in the area of farm program payments, because it is a fairly regular occurrence. When people

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cheat, they are out of the program. They are no longer eligible, period. But you and others contend that we just cannot do that in this area, because it is too complicated.

Ms. SHIKLES. I think in the past, it is just that when they have tried to, they actually have gotten somebody cold. I think there are so many groups that they have to go through, that it has been discouraging because they have had to. You still have these guys still practicing in the medicare program when you know that they have just ripped the program off and owe the program a lot of money.

So I think we need to look at maybe some of the strategies that medicaid used, an up front contract. So we do not have to go to the court system, you violate this, you are out of the program. I think your idea of some type of peer review system is very interesting and worth considering.

One thing that we have the idea of is that beneficiaries are very concerned about this program. And we have done studies where we find that beneficiaries do call in. They scrutinize their bills very carefully. They contact us. I am sure they contact you. They have a financial stake in this program. They are paying out of pocket. They are paying a large premium.

I think it would be very interesting to look at some peer review for the contractors. I mean some group that has a stake in keeping spending under control.

Mr. STENHOLM. I agree with the Chairman's observation when he was saying there needs to be an incentive to an individual beneficiary. If you catch a mistake, there is a financial incentive for you. I am familiar with the Chairman's observation and know it is working in some other areas. I am not sure how you would need to change the peer review system, but any time you have got a peer review of whatever you are doing, it tends to help those of us in government in trying to carry out the system.

Ms. SHIKLES. I think it is time to consider these and some of the other ideas. We have gone on for a long time sort of telling the same story and problems are getting worse. There are enough ideas out there now. Those that you have mentioned that we really need to try. What you need though is leadership in the program. I think, you need a Health Care Financing Administration, administrator who is going to make this a top priority and put a plan in place that says we are going to try some of these new ideas. We are tired of the same old story that more funding is needed; more auditors are needed; more money is lost. It is very frustrating. It is frustrating for us who work in the area as well.

We think there are enough good ideas out there that could be put in place pretty quickly that you might be able to see some changes pretty quickly.

Chairman SABO. Let me ask just one quick question. We have got to go vote. I gather the biggest area of problems are outpatient services; is that accurate?

Ms. SHIKLES. I am sorry.

Chairman SABO. The biggest problem area is outpatients?

Ms. SHIKLES. Yes, that is right.

Chairman SABO. Are most of those subject to a doctor's direction before they are reimbursed or can somebody——

Ms. SHIKLES. All of them.

Chairman SABO. All of them are subject to—so this rolling lab scam, it had to be a doctor telling the folks to go the lab?

Ms. SHIKLES. That is right.

Chairman SABO. As a recipient, I cannot decide that I am simply going to go use X outpatient service when my doctor has not told me to do it?

Mr. DOWDAL. The physician has to either order or prescribe the service in order for it to be eligible to be paid.

Ms. SHIKLES. That is why you want to focus on the physician, because the physician is the one ordering all these other tests. And that is why we have also focused on some legislative remedies here, because we know there are certain standard things that are occurring over and over that are major problem areas; that if they were addressed, we think we would see a lot fewer problems. The fact that physicians do refer patients to facilities where they are investors and it is a major costly problem for medicare for one.

Chairman SABO. Thank you very much.

My apologies for having to be in and out of the room today, but it is the nature of the day. We really appreciate all the good work you have done and I appreciate the opportunity we had to visit in our office earlier and I think members found this hearing very useful.

Ms. SHIKLES. Thank you very much.

Chairman SABO. Keep up the good work and keep us posted.

Ms. SHIKLES. Thank you.

[Whereupon, at 3:50 p.m., the committee was adjourned.]

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